

Assaultive Offender and Sex Offender Questions and Answers

With no outcome data, what is the evidence that what we are currently doing does not work? Program is based on assumption that teaching these skills improves behavior. Don't have #'s but have reports and testimonies from the psychologist that program is working. There isn't evidence that it doesn't work. The current program is research based and relies on cognitive/behavioral principles. Psychologists working with prisoners believe that prisoners make progress in their groups.

MPRI model and how is program aligned with model in terms of continuity of care? Current Program is not the ideal one. Offenders aren't seen at all until they start the program a year before their ERD. Ideally, they'd have programming & assessment available from the beginning of their incarceration, but one of the problems is lack of continuity & exchange of information from the prison to the treatment provider in the community. The MPRI vehicle can be used to address this for the AO/SO population as well. The parole board & treatment providers in the community should have access to treatment continuity plans, update reports and additional info.

What about use of Plethysmograph? Being looked at especially as it relates to research and its effectiveness. It's been discussed, but it hasn't yet been used. We'd be interested in your insight on what kind of screening/ assessment protocols you would suggest.

What is the current number of sex offenders on parole? About 1,000 are on parole at any given point of time. Not a huge population on parole since only about 14% of this population is paroled.

What is the rate of recidivism for Sex Offenders after parole? Sex offenders have the lowest recidivism rate of any classification of offender.

What is the rate of recidivism for violent Sex Offenders after parole? No data available on violent Sex Offenders because it's difficult to gather since we don't know about the crimes that don't come to the attention of the criminal justice system. In addition, it's necessary to look at a much larger timeframe to assess recidivism. The department's annual statistical report is available on the web at www.michigan.gov/corrections. The statistical report is listed under publications and then under legislative reports. Return to prison in a 2 year period is reported. AO rates of recidivism vary substantially by offense.

Do you track recidivism data? It can be found on the web. See link above.

Do they recidivate for the same offenses? About 50% will come back for the same offense.

Can you provide any outcome or measurement data from the current AOP/SOP programs? No, there aren't any standardized measures or outcomes at this time. Really need measure to tell if offender is getting the information through treatment to make changes.

What other standardized instruments do you use for AOP/SOP other than COMPAS & VASOR? We had a psych. Program at one point which used several scales to look at specific issues related to SO/AO. Specific therapists can use these if they want to but they don't use and specific tool regularly. The static is being reviewed as a possible assessment tool. It may be combined with a dynamic assessment. Measurement among youth and women is a challenge.

Have you considered the HAIR? It requires a therapist and is time and resource intensive.

Is there a standardized assessment protocol? Not a set protocol for assessment at this time. Variety of questionnaires used for assessment in addition to COMPAS & VASOR. Static02/Static99 is being looked at as a tool. Research is still being done on validity and reliability. Youth & women are a chronic problem for assessment. No good risk assessments for females. Acute and stable measures reviewed in determining treatment.

Use of polygraph more frequently? Under CASOM, polygraph examiner is a regular participant of program. When on parole, this group gets 2 polygraphs. Polygraphs are currently being used in 3 counties but believe in use and would like to integrate into treatment. Finding more polygraph examiners is challenging.

Is a containment model used in the community by parole agents/treatment providers? Yes Kalamazoo CASOM Program

How do parole agents currently assess risk of their offenders in the community? Have screening at reception center (high/med/low) and every offender comes out with risk assessment that shows how likely to commit crime. Which is then used to determine level of supervision, and agents will use TAPS in future to determine supervision.

What about the needs for female offenders and how will they be written into the proposal? We are asking for proposals to address gender differences in assessing risk and looking at any individual characteristic that is important for risk. We want to learn more about programs for women

Are you issuing separate proposals for AOP and SOP or one proposal addressing both issues? This would be up to the vendor, they can submit one proposal for both or two separate ones but, must address needs of different populations.

Do you have any data regarding the number of unsuccessful housing placements for sex offenders? No we don't track unsuccessful placements because there are too many

restrictions. There is anecdotal information. Study out of Minnesota that demonstrates that residency restrictions do not work and difficult to supervise those with restrictions.

Is treatment mandated by statute? No, have an automatic admission policy to the program based upon the offender's crime. Program is voluntary and offenders can choose not to participate. They used to get clients into treatment by referral and review of record. They now use an electronic system that recommends clients based upon their crime. Prisoners used to be weeded out through record review/assessment prior to joining the group.

Are services centrally located? All facilities offer services.

How productive or useful is the COMPAS? COMPAS is a broadband risk assessment and needs to be supplemented to assess SOP/AOP risk. COMPAS is effective at predicting risk, but this research is not based on MI population. There is a compelling body of evidence that COMPAS can predict risk and need assessment. It isn't specific to the needs of sex offenders.

Is COMPAS at RGC? COMPAS will be used at all intake facilities this fall. We are currently using COMPAS at 14 facilities and in process of training staff and parole agents.

Does it matter who administers COMPAS? Yes, working on training staff so it is more standardized and done by Corrections Program Coordinators. Interviewing skills required are different from current staff skills. In addition, some data will be auto populated from the electronic record system.

MMPI administered at RGC? Yes, Have they been cross validated?
They won't likely be cross validated.

Is there anything in place for reentry (MPRI) for sex offenders? One demonstration project in Kalamazoo is working with community, parole board etc. to supplement a coordinated effort with MPRI.

Is the model in Kalamazoo based on research? Kalamazoo model is based on Center for Sex Offender Management and protocol that addresses 7 different priority areas driven by formal assessment protocol. A general statement describing the program will be on the web. Program is only 6 months into implementation, so it's too early for results. CASOM-Comprehensive Assessment Sex Offender Program

Questions Submitted after the Meeting

1&2 **How many of MDOC's prison facilities offer the current AOP/SOP program? How many psychologists (that run the AOP/SOP program) are located at each of those facilities?** AOP and SOP are offered at 39 Level I and II facilities by approximately 90 psychologists who run both

types of groups. The number of psychologists at a facility ranges from 1 to 5.

3. **Is MDOC looking to continue both the AOP and SOP programs at the existing prison facilities or is there an expectation to increase the number of sites that will offer these programs?** There are no set expectations. MDOC is interested in reorganizing the programs to best meet the needs of the offenders and the department. This could mean a reduction in the number of facilities at which programming is offered, a change in the security levels, a decrease in the number of prisoners recommended, etc.
4. **What does it cost MDOC to operate the current AOP and SOP programs?** AOP and SOP costs are imbedded in health care and custody costs without a specific allocation to AOP or SOP. Using the standard that 50% of a psychologists' time is devoted to the programs a cost of \$5,000,000 per year would be reasonable estimate.
5. **Is there a waiting list with the current AOP and/or SOP programs?** *Yes.* Waiting lists are defined as those prisoners with AOP or SOP recommendations who are within 6 months or less of their earliest possible release date (ERD). Currently there are 164 and 133 for AOP and SOP respectively. We track prisoners and work to place them in group up to one year before their ERD. At present we have 205 AOP or SOP identified to enter or transfer for group by the end of May.
- 6&7 **What does MDOC do with prisoners who are developmentally disabled that qualify for either AOP or SOP? Are they ineligible for these programs? Is there another program/treatment option available? How does MDOC handle prisoners who are deaf, or speak limited to no English, or who are severely mentally ill that qualify for AOP or SOP? Are they ineligible for these programs? Is there another program/treatment option available?** Special needs prisoners, (mentally ill, hearing impaired, foreign language speaking, developmentally disabled) are accommodated in a variety of ways. In some cases programming is offered in the special housing or treatment units in which they reside. In other cases individual accommodations are made.